Mountain-Pacific Quality Health Foundation

Request for Medicaid Home Infusion Therapy Authorization

Home IV

Contact Person:

Please Type or Print

Patient Name:(Last), (First) (MI)	Medicaid Number	Date of Birth

Physician Name	City, State ZIP	Phone Number	Fax Number

Provider #	Provider Name	Phone Number	Fax Number

Street Address	City	State	ZIP

Date Therapy Initiated:	**Is this an extension of an existing PA?**	**Yes**	**No**

Pertinent Information: (C&S, chart notes, etc) Attached?

Diagnosis:

Additional Comments:

SERVICES TO BE AUTHORIZED

From	Thru	Procedure	Modifier	Days	Therapy
1.					
2.					
3.					
4.					
5.					

MAIL or FAX COMPLETED FORM TO:

DRUG PRIOR AUTHORIZATION UNIT
Mountain-Pacific Quality Health Foundation
3404 Cooney Drive
HELENA, MT 59602
(406)443-6002 or 1-800-395-7961 (PHONE)
(406)443-7014 or 1-800-294-1350 (FAX)

LEAVE BLANK - PA UNIT USE ONLY

REASON FOR DENIAL OF THERAPY PRIOR AUTHORIZATION

IMPORTANT NOTE: In evaluating requests for prior authorization, the consultant will consider the therapy from the standpoint of published criteria only. If the approval of the request is granted, this does not indicate that the recipient contines to be eligible for Medicaid. It is the responsibility of the provider of service to establish of the recipient's Medicaid eligibility.

CURRENT RECIPIENT ELIGIBILITY MAY BE VERIFIED BY CALLING ACS AT 1-800-624-3958 or 406-442-1837

Approval / Denial Status	Approve/Deny Code	Therapeutic Class	Auth.ID	Date of Request	Prior Authorization Number